

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN556S	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/20/2009
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation for conducted in your facility on 5/20/09, in accordance with Nevada Administrative Code, Chapter 449, Skilled Nursing Facilities. Complaint #NV00022079 was substantiated with deficiencies cited. (See Tag Z 301) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	Z 000		
Z301 SS=A	NAC 449.74491 Prohibited practices 2. A facility for skilled nursing shall adopt procedures which ensure that all alleged violations of the policies adopted pursuant to subsection 1 and injuries to patients of unknown origin are reported immediately to the administrator of the facility, to the bureau and to other officials in accordance with state law, and are thoroughly investigated. The procedures must ensure that further violations are prevented while the investigation is being conducted. This Regulation is not met as evidenced by: Based on interview and observation, the facility failed to report to the bureau an injury of unknown origin per facility policy and regulation for one resident. (Resident #1) Findings include: Resident #1: The resident was admitted to the	Z301		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN556S	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/20/2009
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA			STREET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Z301	<p>Continued From page 1</p> <p>facility on 4/17/09 with diagnoses including status post fractured hip with pinning, hypothyroidism, vascular dementia, and hypertension.</p> <p>On or about May 14, 2009 a bruise was discovered on resident's upper eyelid. The facility did notify the daughter of the injury, but failed to report the incident to the Bureau as required by facility policy and state regulation. Observation of Resident #1 did show a black eyelid which no one could explain, including the resident. The injury appeared to be the result of a blood vessel rupture near the eyelid. There did not appear to be any abuse of the resident, nor did she complain of any discomfort from the injury. The resident remained smiling and pleasantly confused.</p> <p>Interview with the Director of Nursing revealed the incident had not been reported to the Bureau as required.</p> <p>Severity: 1 Scope: 1</p>	Z301			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.